Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN ANTONIO SPINE & REHAB
1313 SE MILITARY DRIVE SUITE 107
SAN ANTONIO TEXAS 78214

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
SAN ANTONIO ISD

Carrier's Austin Representative Box
Box Number 43

MFDR Tracking Number
M4-11-2393-01

MFDR Date Received
March 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauth was obtained, AUTH #B832."

Amount in Dispute: $1,033.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 was placed in the carrier representative box 16 on March 18, 2011, was picked up by Jamie Roberts on March 22, 2011. A findings and decision will therefore be issued with the information provided to MFDR at the time of the review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2010 through November 2, 2010	97110, G0283 and 97140	$1,033.90	$886.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the preauthorization, concurrent review and voluntary certification of healthcare guidelines.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated November 16, 2010, November 17, 2010
   - 216 – Based on the findings of a review organization.

   Explanation of benefits dated January 6, 2011
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 216 – Based on the findings of a review organization.

Issues

1. Did the requestor obtain preauthorization for the disputed charges?
2. Did the requestor submit documentation to support the billing of the disputed CPT codes?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care...(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."
    - Review of the preauthorization letter dated October 8, 2010 from Sedgwick CMS indicates that preauthorization was approved for 97110 (12 units), 97140 (24 units) and G0283 with a start date of October 8, 2010 through November 30, 2010.
    - The requestor disputes non-payment of CPT codes 97110, 97140 and G0283 rendered on October 27, 2010, October 29, 2010, November 1, 2010 and November 2, 2010 preauthorized by the insurance carrier.
    - The requestor obtained preauthorization for the services in dispute with the exception of 4 units of CPT code 97110 rendered on November 2, 2010.
    - The requestor billed 4 units of 97110 on October 27, 2010, October 29, 2010, November 1, 2010 and November 2, 2010 for a total of 16 units. Reimbursement is therefore recommended for 12 units of CPT code 97110, however reimbursement cannot be recommended for 4 units of 97110 rendered on November 2, 2010 as it exceeds the preauthorized number of units (12 units).
2. 28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute..."
    - The requestor submitted medical records in the form of SOAP notes, which documented that the disputed services were rendered as billed.
    - The requestor billed 4 units of 97110 on October 27, 2010, October 29, 2010, November 1, 2010 and November 2, 2010 for a total of 16 units. Reimbursement is therefore recommended for 12 units of CPT code 97110, however reimbursement cannot be recommended for the 4 units of 97110 rendered on November 2, 2010 as it exceeds the preauthorized number of units (12 units).
    - The requestor billed two units of CPT code 97140 on October 27, 2010, October 29, 2010, November 1, 2010 and November 2, 2010 for a total of 8 units. Reimbursement is therefore recommended for 8 units of CPT code 97140.
    - The requestor billed one unit of CPT code G0283 on October 27, 2010, October 29, 2010, November 1, 2010 and November 2, 2010. Reimbursement is therefore recommended for 4 units of CPT code G0283.
    - The requestor is therefore entitled to reimbursement for the CPT codes noted above, per 28 Texas Administrative Code §134.203.
3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83... (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."
    - Reimbursement for CPT code 97110 is $41.87/unit. The requestor billed and documented 4 units on October 27, 2010, October 29, 2010 and November 1, 2010 for a total of 12 units. Reimbursement is recommended in the amount of $41.87 x 12 units = MAR $502.44.
    - Reimbursement for CPT code 97140 is $39.26/unit. The requestor billed and documented two units on October 27, 2010, October 29, 2010, November 1, 2010 and November 2, 2010 for a total of 8 units. Reimbursement is recommended in the amount of $39.26 x 8 units = MAR $314.08.

- Reimbursement for CPT code G0283 is $17.50/unit. The requestor billed and documented one unit on October 27, 2010, October 29, 2010, November 1, 2010 and November 2, 2010 for a total of 4 units. Reimbursement is recommended in the amount of $17.50 x 4 units = MAR $70.00.
- The requestor is therefore entitled to a total reimbursement of $886.52.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $886.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $886.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.